patient." Many readers may miss this subtle point, and confuse the table with a reliable means for stratifying risk for postoperative respiratory complications, as well as the need for postoperative respiratory monitoring. Risk stratification for opioid-induced respiratory depression is by no means an exact science, and failure to rescue remains a significant source of human suffering and healthcare expense. The Anesthesia Patient Safety Foundation recognizes this fact, and has stated "…risk stratification for increased postoperative electronic monitoring would potentially miss a large population of patients that is at increased risk for opioid-induced respiratory depression."[2] Not surprisingly, the Anesthesia Patient Safety Foundation has advocated for continuous respiratory monitoring for *all* postoperative patients receiving parenteral opioids.

By all means, practice guidelines should help providers make sound clinical decisions when solid scientific evidence is lacking. The inclusion of an untested numerical risk assessment scale, however, has no place in such a document, even if there is a disclaimer in the fine print.

Competing Interests

The author declares no competing interests.

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Postoperative Continuous Positive Airway Pressure Treatment in Surgical Patients with Obstructive Sleep Apnea

To the Editor:

With the increasing incidence of patients with obstructive sleep apnea (OSA) presenting for surgery and the associated risks for perioperative complications in these patients,[1] evidence-based recommendations for the appropriate management are of great importance for healthcare providers.

The authors of the updated "Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea" have given such recommendations in regard to the pre-, intra-, and postoperative management based on the limited evidence (scientific or opinion-based) available.[2]

Concerning the important question of oxygenation as part of the postoperative management, the authors of these Guidelines relate to a trial by Neligan et al.,[3] stating that this study indicated "improved ventilatory function for OSA patients when postoperative CPAP [continuous positive airway pressure] is compared with no postoperative CPAP."

In my opinion, this is an incorrect description and interpretation of the cited study, which measured spirometric lung functions in morbidly obese patients with known OSA before and after laparoscopic bariatric surgery.

In fact, postoperative CPAP therapy was given to ALL subjects in this study (initiated 30 min after extubation in the postanesthesia care unit *via* identical noninvasive ventilators and continued for a minimum of 8 h). However, patients in this study were randomly assigned to receive either early CPAP *via* the so-called Boussignac system (Boussignac group) or supplemental oxygen (standard care group) IMMEDIATELY after extubation and ONLY UNTIL the commencement of postoperative CPAP therapy in both groups, resulting in better maintained lung functions in the Boussignac group.

While the study by Neligan et al. may be indicative of a potential benefit of an early *versus* delayed begin of CPAP therapy, it may not be utilized regarding the value of postoperative CPAP let alone oxygenation *per se*. Well-controlled studies demonstrating a beneficial effects of CPAP for patients with OSA in the postoperative period are still lacking.

In conclusion, clearly more data is needed to strengthen the scientific basis of the important practice guidelines for the perioperative management of patients with OSA.

Competing Interests

The author declares no competing interests.

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